96TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
No. 96-977

MENTAL HEALTH SYSTEMS ACT

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

together with

DISSENTING VIEWS

[To accompany H.R. 7299]

[Including cost estimate of the Congressional Budget Office]

MAY 15, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Public Laws: 96th Congress / 2nd Session / 1980

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MENTAL HEALTH SYSTEMS ACT

MAY 15, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

together with

DISSENTING VIEWS

[To accompany H.R. 7299]

[Including cost estimate of the Congressional Budget Office]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 7299) to revise and improve the Federal programs of assistance for the provision of mental health services, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 6, strike out "or other entity" in lines 1 and 5.

Page 9, line 6, strike out "payments under" and insert in lieu thereof "the purposes of making" and, beginning in line 13, strike out "payments under".

Page 10, insert after the period in line 2 the following:

> No grant may be made under this subsection to a public entity (other than a State mental health authority) or a nonprofit private entity for the provisions of services in a mental health service area served by a community mental health center.

Page 11, insert after the period in line 13 the following:

> No grant may be made under this subsection to a public entity (other than a State mental health authority) or a nonprofit private entity for the provision of services in a mental health service area served by a community mental health center.

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Page 14, insert after line 5 the following:

The Secretary may not approve an application of an entity which has received a grant for three years under subsection (a) unless the applicant is providing all the mental health services described in paragraph (4) (A).

Page 17, line 14, strike out "a grant" and insert in lieu thereof "grants".

Page 20, line 20, insert "providing" after "and".

Page 22, line 11, strike out "payments under" and insert in lieu thereof "the purpose of making".

Page 23, line 12, strike out "payments under" and insert in lieu thereof "making".

Page 25, line 20, strike out "except after" and insert in lieu thereof "unless the State agency has been provided" and in line 21 strike out "to the State".

Page 25, line 25, strike out "502" and insert in lieu thereof "402".

Page 26, strike out lines 19 through 21 and insert in lieu thereof the following:

(A) provide that the State agency will resume re-

Page 27, line 4, strike out "nongovernment" and insert in lieu thereof "nongovernmental".

Page 31, line 1, insert ", to be assisted by a grant under title I," after "project".

Page 33, insert after line 8 the following:

(5) satisfactory assurances that the applicant has in effect a system, satisfactory to the Secretary, to assure that an employee of the applicant who reports to any officer or employee of the Department of Health and Human Services or appropriate State authority any failure on the part of the applicant to comply with an applicable requirement of this Act or regulation of the Secretary or requirement of State law will not on account of such report be discharged or discriminated against with respect to the employee's compensation or the terms, conditions, or privileges of the employee's employment;

(6) satisfactory assurances that each facility to be used in the provision of health or support services to be supported by the grant applied for meets the requirements of applicable fire and safety codes imposed by State law;

Page 33, line 9, strike out "(5)" and insert in lieu thereof "(7)".

Page 33, line 11, strike out "(6)" and insert in lieu thereof "(8)".

Page 33, line 20, strike out "(7)" and insert in lieu thereof "(9)".

Page 34, line 1, strike out "(8)" and insert in lieu thereof "(10)".

Page 34, line 3, strike out "(9)" and insert in lieu thereof "(11)".

Page 34, line 8, strike out "under this Act" and insert in lieu thereof "under titles I and II".

Pages 36, line 20, strike out "this Act" and insert in lieu thereof "section 102".

Page 37, line 10, strike out "to" and insert in lieu thereof "of".

Page 38, line 15, strike out "providing" and insert in lieu thereof "the center shall have".

Page 43, line 16, strike out "this title" and insert in lieu thereof "this Act".

Page 43, insert after line 16 the following:

(1) The term "Secretary" means the Secretary of Health and Human Services.

Page 43, line 17, strike out "(1)" and insert in lieu thereof "(2)".

Page 44, line 1, strike out "(2)" and insert in lieu thereof "(3)".

Page 44, line 4, strike out "(3)" and insert in lieu thereof "(4)".

Page 45, line 13, strike out "of Health and Human Services".

Page 47, line 19, strike out "payments under".

Page 50, line 5, strike out "$40,000,000" and insert in lieu thereof "$4,000,000".

Page 51, beginning in line 23 strike out "which the length of the service so performed is of the length of the service so required to be performed" and insert in lieu thereof "of the length of the service so required to be performed which has not been performed".

Legislative Background

Legislation to improve the provision of mental health services and otherwise promote mental health throughout the United States; and for other purposes, H.R. 4156, was introduced on May 21, 1979, by Mr. Staggers, Mr. Waxman, Mr. Preyer, Mr. Maguire, Mr. Leland, and Mr. Carter. Hearings were held on H.R. 4156, H.R. 3986 (to amend the Community Mental Health Centers Act to provide for further research and services with regard to victims of rape), and all similar or identical bills on June 14, 25, and 26, 1979. In addition, a hearing on community support programs for the mentally ill was held on October 11, 1979, and an oversight hearing on the community mental health centers program was held on February 5, 1980. The bill was subsequently considered in open session by the Subcommittee, amended, reported by a recorded vote of 9–2 on May 7, 1980, and reintroduced as H.R. 7299, to revise and improve the Federal programs of assistance for the provision of mental health services; and for other purposes, by Mr. Waxman, Mr. Preyer, Mr. Maguire, Mr. Luken, Mr. Walgren, Mr. Gramm, Mr. Leland, Mr. Shelby, and Mr. Murphy of New York on May 7, 1980.

H.R. 7299 was considered in open session by the Committee on Interstate and Foreign Commerce, amended, and ordered to be reported by a vote of 19–3 on May 13, 1980.

Summary of Legislation

Existing authority for most programs supported under the Community Mental Health Centers Act expires at the end of fiscal year 1980. This measure provides: (1) extensions and revisions of these programs; (2) reforms in the existing mental health service delivery system; and (3) authorizations of appropriations through fiscal year 1984. The principal provisions of H.R. 7299, as reported by the Committee on Interstate and Foreign Commerce, include:

(1) Extension of programs supported under the Community Mental Health Centers Act through fiscal year 1981;

(2) Beginning in fiscal year 1982, establishment of a revised system of mental health service support under which the Secretary is authorized to make grant awards for community mental health services, for State mental health programs, and for prevention;

(3) Authorization for the Secretary to make grant awards to provide services for victims of rape, the chronically mentally ill, severely mentally disturbed children and adolescent and priority populations (identifiable population groups within a mental health service area without a community mental health center which have been determined by State and local planning processes to be unserved or underserved by mental health service programs), and to demonstrate prevention techniques;

(4) Authorization for the Secretary to make grant awards to those community mental health centers which have completed their initial period of operations support to assist in meeting the costs of providing non-revenue-producing services (consultation and education, follow-up services, and program administration);

(5) Expansion of the role of the State Mental Health Authority by requiring as a prerequisite to the receipt of Federal grant support the recommendation of such authority for funding of any grant for a new community mental health center, any preparation grant, any grant for services to priority populations, and, beginning in fiscal year 1984, any new grant for non-revenue producing services;

(6) Authorization for the Secretary to make grant awards to assist ambulatory health care centers to provide mental health services to their patients;

(7) Authorization for the Secretary to make grant awards for job retraining of mental health workers adversely affected by changing delivery systems, and for other innovative projects in the area of mental health services delivery;

(8) Establishment of an Associate Director for Minority Affairs within the National Institute of Mental Health; and

(9) Inclusion of a requirement for special pay provisions for physicians and dentists in the Commissioned Corps of the Public Health Service which are identical to those for similar health professionals in the Armed Services.

Cost of Legislation

H.R. 7299 provides specific authorizations of appropriations for programs supported under the Community Mental Health Centers Act, as extended by the Mental Health Systems Act through fiscal year 1981 (Table I), and for programs of the Mental Health Systems Act for fiscal years 1982, 1983, and 1984 (Table II).

As reported by the Committee on Interstate and Foreign Commerce, the bill would provide total specific authorizations of appropriations of $78 million for fiscal year 1981; $152 million for fiscal year 1982; $177.5 million for fiscal year 1983; and $200 million for fiscal year 1984.

TABLE I.—COMMUNITY MENTAL HEALTH CENTERS ACT—MENTAL HEALTH SYSTEMS ACT, FISCAL DATA AND PROPOSED AUTHORIZATIONS OF APPROPRIATIONS FOR FISCAL YEAR 1981 IN H.R. 7299[1]

[In millions of dollars]

	Fiscal year 1978		Fiscal year 1979		Fiscal year 1980		Fiscal year 1981 authorization proposed in H.R. 7299
	Authorization	Appropriation	Authorization	Appropriation	Authorization	Appropriation	
Community Mental Health Centers Act:							
Planning (202)(d)	1.9	0	1.5	0	1	0	1
Initial operations (203)(d)(1)	38.9	26.387	34.5	30.489	35	35.0	37
Consultation and education (204)(c)	15.0	8.245	20.0	10.136	3	12.465	15
Conversion (205)(c)	23.0	19.372	30.0	11.801	25	1.84	
Financial distress (213)	13.5	5.488	25.0	10.510	0	12.01	15
Continuing operations (203)(d)(2)		198.11		247.289		229.028	
Rape prevention (231)(d)	7.88	4.436	8.0	3.624	9	4.158	4
Services for rape victims							6
State mental health programs—(314)(g)—Public Health Act	NA	NA	5.0	0	2	0	(2)
Total	100.18	262.038	124.0	313.849	75	294.501	78

[1] Appropriations columns reflect funds appropriated for 'continuing operations', which do not have a specified authorization level.
[2] Authorized in Public Law 95-622.

TABLE II.—MENTAL HEALTH SYSTEMS ACT, PROPOSED AUTHORIZATIONS OF APPROPRIATIONS IN H.R. 7299

[In millions of dollars]

	Fiscal year—		
	1982	1983	1984
Title I—Community mental health services:			
Preparation	1	1.0	1
Community mental health Centers, initial operations	24	27.0	30
Chronically mentally ill	33	38.0	43
Severely mentally disabled children and adolescents	7	8.0	9
Priority populations	16	18.0	20
Nonrevenue producing activities	35	40.0	45
Mental health in ambulatory centers	15	17.5	20
Title II—State programs:			
Administration improvement	3	4.0	5
Pilot projects	3	4.0	5
Title III—Prevention: Demonstration	6	8.0	10
Title VI—Rape services support program: Services for rape victims	9	12.0	12
Total	152	177.5	200

Committee Proposal

1. BACKGROUND AND NEED

A. Early Federal Efforts

In October 1963, the Congress approved and sent to President Kennedy legislation authorizing limited Federal financial assistance for the States to aid them in the construction of community-based mental health centers. Such centers, the Congress believed, could be more effective in dealing with the problems of treating the mentally ill than the institutional programs of State and county mental health hospitals scattered across the United States. It was hoped that community-based treatment programs would replace large institutions as the locus for dealing with the mental health problems of the country.

As approved by the President, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88–164) entitled each of the States to an allotment of Federal funds on the basis of three considerations: (1) population, (2) the extent of facility need, and (3) the overall financial need of the respective States. Each State was required to develop a comprehensive mental health plan, together with a list of priorities for action regarding the mental health activities proposed by the State. States were also required to provide assurances that the services of centers would be available to all and that a reasonable amount of care would be provided to indigent persons.

Congress passed the Community Mental Health Centers Construction Act Amendments of 1965 (Public Law 89–105) under which grant funds were also available for the initial staffing costs of professional and technical personnel incurred by centers constructed under the 1963 program and similar costs for centers already in existence which were proposing to add new or additional mental health services to their programs. In October 1968, the scope of the Community Mental Health Centers Act was broadened by adding new programs of construction and initial staffing assistance for centers and other specialized facilities for the treatment of alcoholism and narcotic addiction. Under the Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968 (Public Law 90–574), facilities were entitled to grant assistance in amounts not to exceed two-thirds of the costs of facility construction. Congress also authorized States (subject to a "maintenance of fiscal effort" provision) to use 2 percent of their allotment funds (not to exceed $50,000) to meet the costs of program administration.

Originally, the Community Mental Health Centers (CMHC) program had been designed to provide basic "seed" money for the purposes of constructing community facilities and to help centers meet their initial costs of operation. But in 1970, Congress concluded that, because State and local sources of funding had proved to be inadequate, additional Federal support would be needed to promote and continue the development of center programs throughout the United States. Under the Community Mental Health Centers Amendments of 1970 (Public Law 91–211), the Federal share of the costs of center construction was increased. The declining Federal matching formula used to determine the share of staffing costs was also changed. Centers not in poverty areas became entitled to grants over an 8 year period (rather than for 51 months). Centers located in poverty areas received assistance for the same period of time but were eligible to apply for a higher percentage of support.

A number of other changes were made by the 1970 Amendments. The percentage of State allotments authorized to meet administrative costs was raised from 2 to 5 percent, although the overall limit of $50,000 was retained. A new program of initiation and development grants was added for the purpose of assessing local needs for mental health services, designing center programs, and developing services. A new program for children's mental health services was incorporated into the Act, including construction and staffing assistance and grants for training and evaluation purposes. Also added was a program of direct grants for special projects relating to alcoholism and narcotic addic-

tion. Funds were authorized for consultation services provided in centers and specialized treatment facilities.

In its review of the Community Mental Health Centers program in 1974, the Congress determined that, because of the patchwork history of the program, it was necessary to provide a clear definition of a CMHC and prescribe the comprehensive mental health services which such a center must provide in order to be eligible for funding. The definition contained requirements for the organization and operation of such centers, provision of services, coordination of services with other entities and development of an integrated system of care, staffing, availability of services, responsiveness to the community served, governing bodies, and quality assurance. The new definition also required each CMHC to provide all stipulated services as a condition to receiving support. These requirements were incorporated into the extensive revision of the Community Mental Health Centers Act accomplished under the Health Revenue Sharing and Health Services Act of 1975 (Public Law 94–63). The revision required all existing centers, as well as new centers, to meet the revised definition and requirements within two years, as a condition of obtaining or continuing to receive grant support. It also created the National Center for the Prevention and Control of Rape, which conducts research into the legal, social, and medical aspects of rape.

At the time of the 1975 amendments, concern was expressed about the financial viability of CMHCs following their eighth and final year of federal operations support. This concern was particularly acute in view of the limited third party payments available to such centers under the Medicaid and Medicare programs and most private insurance plans. For that reason, a program of financial distress grants was devised which authorized grants to be made to centers experiencing financial distress if such centers agreed to comply with additional requirements to assure that reforms designed to relieve that distress without curtailing services would be instituted. A provision was included that no more than three such awards could be made to any one center. That provision was amended by Public Law 95–622 to allow up to five such awards to each center. To date, 75 centers have received financial distress grants; all but four are active grants at this time.

To other major grant mechanisms were also established by the 1975 amendments: (1) conversion, and (2) consultation and education grants. The purpose of the conversion grant program was to assist existing centers in meeting the initial costs of instituting those new services required by the 1975 amendments. Conversion grants were to be available for up to 2 years for each such center. To date, 155 centers have received such grants; less than 10 are still eligible for a second such award.

The second new categorical authority, consultation and education, was to be available to centers on an annual basis beginning their fifth year of operations. At the time of the enactment of the 1975 Amendments, the Congress expressed concern that consultation and education was a vital program element for which third party reimbursement was unavailable. This new authority was developed as an appropriate mechanism to assure the provision of this service. To date, 134

centers have received consultation and education grants. All 134 are active at this time; only 20 of these centers are still receiving basic Federal operations support.

B. Progress under the Community Mental Health Centers Act

The CMHC program has passed the halfway mark in providing total national coverage of comprehensive community-based mental health services. This has been achieved with a Federal expenditure of approximately $2.29 billion over 13 years. This Federal CMHC investment has generated well over double that amount in State and local funds and receipts for community mental health services. More importantly, as a result of this legislation and other Federal and State initiatives, there has been a dramatic shift from inpatient to outpatient mental health care. Over the last ten years, utilization rates for outpatient care have increased fourfold; while, between 1979 and 1977, there has been a decrease by 36 percent in the number of psychiatric hospital beds in the United States.

Since the inception of the program, Federal funds have assisted in the initiation of 763 CMHCs, making clinical care, preventive services, and social services available to over 110 million people, or 50 percent of the total population. Over 712 of the centers are fully operational and, in 1979, provided direct services to over 2.4 million persons. HEW estimates that the average number of visits per patient is 6 per year, with an average annual patient cost of approximately $400. Of the remaining 735 catchment areas without funded CMHCs, approximately 50 have no direct access to mental health services.

By the end of fiscal year 1979, 179 CMHCs had received their first operational support through initial operations grants under the 1975 Amendments. As an indication of the continuing interest in the program, 67 groups in unfunded catchment areas have initiated activities to develop CMHC programs with Federal assistance. Twenty-seven of these groups have received planning grants; the remaider have approvable applications for planning or initial operations grants and are awaiting the availability of Federal funds.

By the end of fiscal year 1979, 325 centers had terminated basic operations support, and 167 had terminated all support.

C. Public Law 95–622

During the 95th Congress, the Community Mental Health Centers program was again reviewed, and legislation providing authorizations of appropriations through fiscal year 1980 was adopted (Public Law 95–622, Title I). Public Law 95–622 provides three basic changes in the community mental health centers program:

(1) It allows new centers to begin with six basic services (inpatient, outpatient, emergency, screening and referral, followup, and consultation and education) and a plan, approved by the Secretary, for providing all other mandated services within a three-year period. This flexibility was felt to be important to encourage new centers to begin operations.

(2) It provides for the sharing of certain services between and among catchment areas. This provision was designed to avoid unnecessary duplication; and

(3) It allows Community Mental Health Centers operated by hospitals or government agencies to have citizen advisory boards rather than governing boards.

Several other provisions of Public Law 95–622 also affect CMHC programming. These include authority for a maximum set aside of 3 percent of each fiscal year's appropriations (or $4 million, whichever is greater) for technical assistance and State compliance monitoring activities; authority for existing children's centers to continue to receive the same 8-year operations support available to CMHCs; streamlining procedures for grant review by the National Advisory Mental Health Council; and a requirement that, to the extent practicable, CMHC catchment area boundaries should not cross health service areas (HSA) boundaries.

Two major provisions of the Commerce Committee passed bill were not incorporated in Public Law 95–622. The first was a series of requirements designed to formally integrate mental health planning into the National Health Planning process mandated by the National Health Planning and Resource Development Act of 1974 (Public Law 93–641). While planning for mental health needs had always been considered by the Committee to be an integral component of the health planning process, not all States have moved to include mental health in their State health planning activities. The major mental health planning proposals adopted by the Commerce Commmittee in the 95th Congress were enacted by the 96th Congress a part of the Health Planning and Resources Development Amendments of 1979 (Public Law 96–79).

The second major Committee provision which was not incorporated in Public Law 95–622, was the proposed Supplemental Support Grant. The Committee provided for the replacement of three existing grant authorities—financial distress, conversion, and consultation and education—by one new authority, with an incremental repeal of those existing authorities. The new authority, Supplemental Support Grants would have provided post-eighth year assistance in meeting the costs of nonreimbursable services (consultation and education, follow-up, and program administration) beginning in fiscal year 1979. The amount of each Supplemental Support Grant to a center would have been determined by the Secretary, but could not exceed $1 per capita for the catchment area served by the center. No limit was set on the number of Supplemental Support Grants a center might receive because the Committee felt that those nonreimbursable services assisted by this grant should be continued.

This proposal was designed to meet continuing concern about the financial viability of Community Mental Health Centers following their eighth year of operations support; concern which continues to be particularly acute as a result of the limited third party payment availability to such centers.

D. The President's Commission on Mental Health

By Executive Order of February 17, 1977, President Carter established the President's Commission on Mental Health to review the mental health needs of the nation, and to make recommendations to the President as to how the nation might best meet those needs. The First Lady, Rosalynn Carter, served as Honorary Chairperson of the Commission.

The 21-member Commission, assisted by its task panels of approximately 450 individuals knowledgeable in the area of mental health, held a series of public hearings throughout the country, and presented

its four volume Report to the President in April 1978. That report made a series of recommendations in each of eight areas (community supports, services, insurance, personnel, basic rights, knowledge, prevention, and public understanding) and cited three mental health related areas for special attention: alcohol-related problems, the misuse of psychoactive drugs, and mental retardation.

The text of the letter of transmittal from the Commission to the President is reprinted here to indicate the scope of its recommendations:

The PRESIDENT,
The White House,
Washington, D.C.

DEAR MR. PRESIDENT: We present for your consideration the Final Report of the President's Commission on Mental Health.

The one-year study we undertook at your direction has convinced us that a substantial number of Americans do not have access to mental health care of high quality and at reasonable cost. For many, this is because of where they live; for others, it is because of who they are—their race, age, or sex; for still others, it is because of their particular disability or economic circumstances.

Mental health services in this country are located predominantly in urban areas. For those who live in rural areas, small towns, and many of the poorer sections of the Nation's cities, specialized mental health facilities and personnel are frequently nonexistent, and the services available are rarely comprehensive.

For many members of America's ethnic and racial minority populations, the mental health personnel and services that are available are either inadequate or fail to take into account their different cultural traditions.

Many children, adolescents, and older Americans do not have sufficient access to services or to personnel trained to respond to the special needs which are characteristic of their ages.

While not enough is known about the causes and treatment of chronic mental illness, we do know that thousands who are so disabled receive deplorably inadequate assistance.

Our study has also convinced us that, for the long run, the Nation will need to devote greater human and fiscal resources to mental health. We now devote only 12 percent of general health expenditures to mental health. This is not commensurate with the magnitude of mental health problems and does not address the interdependent nature of physical and mental health. We must begin now to seek a realistic allocation of resorces which reflects this interdependence.

Further, since over half the dollars for mental health care are still spent in large State institutions and mental health-related nursing homes, there is an urgent need for a national policy that will alter the current balance of mental health expenditures in order to develop needed community-based services.

Despite shortcomings and inequities, the foundation exists for reaching the goal of making high quality public and private mental health services available at reasonable cost to all who need them. To bring us nearer this goal, during the next decade we must:

Develop networks of high quality, comprehensive mental health services throughout the country which are sufficiently flexible to respond to

changing circumstances and to diverse racial and cultural backgrounds of individuals. Wherever possible these services should be in local communities.

Adequately finance mental health services with public and private funds so that care is available at reasonable cost.

Assure that approximately trained mental health personnel will be available where they are needed.

Make available where and when they are needed services and personnel for populations with special needs, such as children, adolescents, and the elderly.

Establish a national priority to meet the needs of people with chronic mental illness.

Coordinate mental health services more closely with each other, with general health and other human services, and with those personal and social support systems that strengthen our neighborhoods and communities.

Broaden the base of knowledge about the nature and treatment of mental disabilities.

Undertake a concerted national effort to prevent mental disabilities.

Assure that mental health services and programs operate within basic principles protecting human rights and guaranteeing freedom of choice.

To achieve these objectives, we cannot rely solely on the Federal Government.

We must have a strategy developed and implemented by partners—the private sector with the public sector, the Federal Government with State and local governments, those working in mental health with those working in general health and related services. In these new arrangements we must define more clearly areas of responsibility and accountability.

In this year, we have come to a much deeper appreciation of the complexities of mental health and mental illness. Because each involves complicated interactions among so many diverse factors, society's perceptions of them are constantly changing.

We believe our recommended goals and directions are sound for now. They can serve as guides to progress over the next few years. But many of the issues we have addressed will themselves change over time. New knowledge will broaden understanding and may necessarily lead to different approaches.

With the submission of this Report, we complete our work.

We wish to thank you for this opportunity and for your support. We wish to express our particular appreciation to our Honorary Chairperson, Rosalynn Carter. Her dedication to improving care for those in need has given us forceful leadership and sparked a spirit of excitement and hope around the country. For this, all who have been affected by mental health problems and all who work in this field are grateful.

Respectfully,

THE PRESIDENT'S COMMISSION ON MENTAL HEALTH.

Working from the recommendations of the President's Commission, the Department of Health, Education, and Welfare developed the Administration's Mental Health Systems Act which was transmitted to the Congress by the President on May 15, 1979, and introduced as H.R. 4156, on May 21, 1979.

2. PROPOSED LEGISLATION

A. Community Mental Health Services

The existing Community Mental Health Centers (CMHC) Act was designed to address a perceived national need for the availability of comprehensive mental health services at the community level. Under that Act, as amended, new CMHC's must provide, or have available to the individuals they serve, the following services: inpatient; emergency; outpatient; screening; follow-up; consultation and education; day care and other partial hospitalization; transitional half-way house; specialized programs for children and for the elderly; and alcohol and drug abuse programming. Only the first six services are required to be in place on the first day of operation; the remaining required services may be phased in over a three-year period.

Currently under the CMHCs Act, grants may be awarded in the following categories (1.) planning; (2.) initial and continued operations; (3.) consultation and education; (4.) conversion—for centers established prior to 1975 to develop the full complement of services required after that date; and (5.) financial distress.

The Systems Act would modify the current concept of the need for comprehensive services in every community, and would restructure the system of grant awards for community programming by replacing existing grant mechanisms with the following proposed categories: (1.) preparation grants; (2.) grants for community mental health centers; (3.) grants for services for severely mentally disturbed children and adolescents; (4.) grants for services for the chronically mentally ill; (5.) grants for mental health services for "priority populations;" (6.) grants for non-revenue producing activities; (7.) grants for mental health services in ambulatory health care centers; and (8.) grants for innovative projects. In addition, provision is made for the Indian Health Service, acting for Indian tribes or organizations, to apply for any grant authorized under Title I of the Committee Proposal.

The Committee views this new categorization of grant support as a package carefully designed to address most appropriately all existing community mental health service needs. Each grant category will be reviewed independently.

1. Preparation grants.—Under the planning grant provisions of the CMHC Act, the Secretary may make grants to public and nonprofit private entities to plan CMHC programs. Only one such grant may be made for any one service area; the grant award may not exceed $75,000. The grantee must (1) assess the needs of the area, (2) design a CMHC program based on such assessment, (3) obtain area financial and professional assistance and support for the program, and (4) assure community involvement in the development and operation of the program.

The Mental Health Systems Act would continue this program as an authority for the Secretary to make preparation grant awards to assist public or nonprofit private entities to prepare for providing mental health services in a mental health service area. Each preparation grant is limited to a maximum of $75,000. The Committee is aware that not every service area will need this support, and that there have been no appropriations made for planning grants in re-

cent years; nevertheless, recognizing that the development of new services in underserved areas may be difficult, the Committee has elected to authorize this potential source of initial community support.

2. Grants for community mental health centers.—The current service requirement for the initiation of a Federally-funded community mental health center is the provision of a minimum of six mandated services (inpatient, outpatient, emergency, screening, follow-up, and consultation and education) beginning on the first day of operations, with a plan to phase in all other required services within three years. These other services are delineated in the first section of the discussion of the Committee proposal.

As reported by the Committee, the Mental Health Systems Act would continue existing authority and requirements for the initiation and operation of CMHCs; however, consistent with the Committee's view that the State Mental Health Authority should play a greater role in the operation of community programs, eligibility for new initial operations support under this section is limited to CMHCs that are State-operated or have been approved by the State Mental Health Authorty. Approvable applications must be accompanied by assurances from the State Mental Health Authority that the grant and all other funds the center may reasonably expect to receive will be sufficient to meet the cost of operations of the center for that fiscal year. As is currently true, eligibility for such support is limited to eight fiscal years.

The Committee is generally pleased with the progress of existing comprehensive centers, and, while providing greater flexibility for the development of community services through other program authorities to be discussed, restates its commitment to and support for continued emphasis on the development and provision of appropriate comprehensive services in every mental health service area.

3. Grants for the chronically mentally ill.—As reported by the Committee, the Mental Health Systems Act would authorize the Secretary to make grant awards for services to assist the chronically mentally ill. Such services would include case management; assistance in gaining access to medical, dental, mental health, and rehabilitation services; assistance in gaining access to employment and housing; and other support services. The Committee bill requires the Secretary to give special consideration to projects which would supplement existing services and to give priority in awarding grant funds in the following order: (1) approved applications of State Mental Health Authorities; (2) CMHCs; and (3) in areas where CMHCs do not exist, other public and private nonprofit entities.

The Committee is particularly moved by the plight of the chronically mentally ill and intends this new program authorization to serve as a stimulus to the development and expansion of programs not only to provide specific mental health care services to such individuals, but to assist them to lead normal, productive lives as contributors to a complex society.

4. Grants for services for severely mentally disturbed children and adolescents.—As reported by the Committee, H.R. 7299 would authorize the Secretary to make grant awards for mental health services and other support services to mentally disturbed children and adolescents. The Secretary would be required to give priority in awarding

such grant funds in the following manner: (1) State Mental Health Authorities; (2) CMHCs; and (3) in areas where CMHCs do not exist, other public and private nonprofit entities.

The Committee heard several arguments for establishing this authority for children and adolescents as separate and distinct from that to provide services for the chronically mentally ill. Chief among these arguments was the fact that services for emotionally disturbed children and adolescents are different from those provided for chronically mentally ill adults. In addition to specific treatment modalities, services for children and adolescents frequently involve greater family participation and ideally are offered in settings apart from those providing services to chornically mentally ill adults.

The Committee accepts these views and for that reason has proposed this specific program authority. The Committee believes that there is no greater service than that of helping a young child or adolescent to develop into a healthy functioning adult and preventing that person from becoming chronically mentally ill.

5. Grants for Mental Health Services for Priority Populations.— Under the current Community Mental Health Centers Act, the services of a CMHC are to be provided "principally to individuals residing in a defined geographic area" and "within the limits of its capacity, to any individual residing or employed in such area, regardless of his ability to pay for such services. . . ." While services are expected to be available to all residents of the area, the CMHC Act specifically requires "a program of specialized services for the mental health of children . . ." and "a program of specialized services for the mental health of the elderly . . ." to be provided as part of those comprehensive services which must be available. Nevertheless, it was a finding of the President's Commission on Mental Health that certain "priority population groups" were, in particular, unserved or underserved by existing mental health programs. As originally proposed by the Administration, the term "priority population group" was defined to mean "any of the following groups which are unserved by any mental health services program or are undeserved by such a program or programs; children and youth, the aged, the chronically mentally ill, any racial or ethnic minority, Indians and urban Indians (as those terms are defined in the Indian Health Care Improvement Act), the poor, rural residents, or any other group determined by the Secretary to have a special need for services under such a program."

The Committee proposal would define "priority populations" as those identifiable population groups within a mental health service area (without a CMHC) which have been determined by State and/or local planning processes to be unserved or underserved by mental health service programs. In providing this definition, the Committee intends to give maximum flexibility to local communities and to States in identifying those in greatest need of services. The Committee would encourage each planning body to be particularly sensitive to the needs of the elderly, children and youth, women, the chronically mentally ill, and racial and ethnic minorities in defining population groups in need of mental health services.

The Committee also encourages the Department of Health and Human Services to review existing programs for the elderly in all currently funded CMHCs, and to assure that the mandated program of

specialized services for the elderly is not only in place, but also designed and implemented to address the very real needs of this special population group.

As reported by the Committee, H.R. 7299 would authorize the Secretary to make grants to State-run or State-approved entities to provide mental health services to "priority populations." Such grants must be for mental health services which: (1) are designed to serve principally one or more "priority population groups" in a mental health service area, (2) are available to all residents of the area, and (3) are provided in a mental health service area not served by a CMHC. Grantees must provide at least outpatient and two other services during the first three years of their operations; in the fourth and fifth grant years, the grantee must provide outpatient, inpatient, screening, follow-up, consultation and education, and emergency services. These are the basic services now required for initial operations support under the CMHC Act.

"Priority population" grant support is limited to five years; no more than two such grants may be made in a single mental health service area in any one fiscal year. No grantee may receive more than five such grants for service to the same group and no mental health service area may receive more than ten such grants.

The Committee spent many hours debating the design of the proposed program of grants for mental health services for "priority populations." While there was no dispute that certain groups remain unserved or underserved by mental health programming efforts, agreement as to the best way to meet those needs was reached only after careful review and consideration of a variety of program alternatives. The Committee believes that the proposal contained in this bill is one which will assure the initiation of new services to individuals in areas where such services are in great need. Each new "priority population" grant recipient must provide services not only to the population group or groups for which that recipient's program is specifically designed, but also to all residents of the mental health service area in which the project is located. In addition, because the project must, within three years, provide all six basic services required of a new CMHC and because a CMHC can receive eight years of Federal assistance in contrast to the five years provided for a "priority population" project, the Committee has built in an incentive for grantees under this program to move toward comprehensiveness.

6. Grants for Non-Revenue-Producing Activities.—Under existing law, the Secretary may award financial distress grants to any CMHC which has received its full eight years of Federal support and which can demonstrate that without this additional support there will be a significant reduction in the types or quality of services it can provide. As a condition to the receipt of a financial distress award, the CMHC must agree to carry out appropriate operational and financial reforms based on the results of a cost analysis study which it agrees to conduct collaboratively with the Secretary. No more than five such awards may be made to any CMHC.

In addition, the Secretary may award grants to CMHCs specifically for consultation and education services, if such CMHC is no longer eligible for continued operations grants or, in unusual circumstances, if it can demonstrate that without this additional support it would be

unable adequately to provide required consultation and education services. There is no limit on the number of consultation and education grants which an individual center may receive.

In 1978, this Committee proposed, and the House of Representatives adopted, a supplemental support grant program. Under that proposal, the Committee provided for the replacement of three existing grant authorities—financial distress, conversion, and consultation and education—by one new authority, with an incremental repeal of those existing authorities. The new authority, Supplemental Support Grants, would have provided post-eighth year assistance in meeting the costs of non-reimbursable services (consultation and education; follow-up; and program administration) beginning in fiscal year 1979. The amount of each Supplemental Support Grant to a center would have been determined by the Secretary, but could not exceed $1 per capita for the catchment area served by the center. No limit was set on the number of Supplemental Support Grants a center might receive because the Committee felt that those non-reimbursable services assisted by this grant should be continued.

That proposal was designed to meet continuing concern about the financial viability of Community Mental Health Centers following their eighth year of operations support, concern which continues to be particularly acute as a result of the limited third party payments available to such centers.

As reported by the Committee, H.R. 7299 would provide a similar program authority in the form of grants for non-revenue producing activities. Under the Committee proposal, grants would be made to assist in meeting the costs of consultation and education services, follow-up services, and program administration. Eligibility is limited to those CMHCs which have exhausted their eligibility for operations grants and which continue to provide at least the six services required for initial operations support for a CMHC. Beginning in fiscal year 1984, eligibility is further limited to State-run or State-recommended CMHCs. The amount of each grant shall be determined by the Secretary but may not exceed $1.00 per capita for the population of the mental health service area.

In proposing this grant authority, the Committee again recognizes that there are certain services which are important elements of a comprehensive community program for which reimbursement is unavailable. The mere presence of this authority should not, however, encourage centers to diminish in any way their efforts to seek State and local assistance in meeting legitimate program costs. To see that this does not occur, the Committee has limited the number of such grants which a CMHC may receive to five.

7. Grants for mental health services in ambulatory health care centers.—As reported, the Committee bill would authorize the Secretary to make grants to assist ambulatory health care centers to participate in the provision of mental health services to their patients. Eligible applicants would (1) be public or nonprofit private entities which provide at least emergency and outpatient mental health services and consultation and education services, and (2) public or nonprofit private ambulatory health care centers. Each application must include an affiliation agreement between a provider of ambulatory health care services and a mental health care provider.

The Committee received reports from the House Select Committee on Aging that "it is the nursing home and not the public mental hospital that houses the largest number of mentally impaired patients . . . Virtually none of these nursing home patients are receiving any type of mental health care." In addition, the Committee was told that although 70 to 80 percent of all nursing home patients have severe symptoms of mental illness, most are receiving no mental health treatment. Twenty to thirty percent of the people who are labeled as "senile" have conditions which are preventable or reversible if detected early and treated. Studies have shown that, at one time or another, as many as 65 percent of the elderly suffer a significant mood disorder, predominantly depression.

For these reasons, the Committee has included both skilled nursing homes and intermediate care facilities among the entities eligible to participate in this particular program.

The Committee regards this new program effort as one with great potential for maximizing scarce resources and providing needed mental and physical health services to individuals in a single setting. Both of these are goals strongly supported by this Committee.

8. Grants for innovative projects.—H.R. 7299, as reported by the Committee would authorize the Secretary to make grants to public and nonprofit private entities for (1) projects for the training and retraining of employees adversely affected by changes in mental health service delivery systems and for assistance in securing employment, (2) projects for the innovative use of personnel in the management and delivery of mental health services, and (3) other significant innovative mental health projects. For these purposes, the Secretary may obligate up to 5 percent of the funds appropriated under Title I of this Act in any fiscal year. Of the funds so obligated, no less than 50 percent shall be used for training and employment projects.

The Committee fully expects the Secretary to use this discretionary authority, and urges priority implementation of job training and retraining programs for individuals who currently earn less than $20,000 a year and who may be adversely affected by programs of deinstitutionalization.

Finally, the Committee bill would authorize the Indian Health Service, upon request of any Indian tribe or urban Indian organization, to apply to the Secretary for any grant under this title. Such grants would be made on the same terms as apply to non-Federal entities, although, in accord with other provisions of this Act, the Secretary may fund up to 100 percent of the costs of projects to be supported by such grants. Grants may be made even though the project to be funded serves residents of two or more mental health service areas of a State.

B. THE ROLE OF THE STATES

Under the Community Mental Health Centers Act, the role of State Mental Health Authorities has been limited and incompletely defined. The State Mental Health Authority has been assigned the responsibility of preparing a State Plan (which must be consistent with the Title XV State Health Plan); administering or supervising the administration of that State Plan; recommending, in accord with

its State Plan, priority approval for project applications within the State; and, where the Secretary has entered into a specific contractual agreement, monitoring the activities of Federally funded CMHCs within that State. As a result, the degree of State participation in the CMHC program has been highly varied.

In H.R. 7299, as reported, the Committee proposes to involve State Mental Health Authorities more fully and to begin a system of State approvals of new grants which would, over time, make the State a necessary participant in the selection of new programs to be funded under the Act. This proposal arises out of the Committee's concern that the limited contact among Federal, State and local entities has resulted in a lack of coordination of institutional and ambulatory care and in needless duplication of efforts and programs. The Committee is further concerned that, although the overall financial contribution of the States to mental health programming greatly exceeds that of the Federal government, few States have assumed fiscal responsibility for CMHCs. While a State's reluctance to commit funds to a program it may not control is understandable, it is the Committee's intent in proposing the Act that future provision of community mental health care emphasize State and non-Federal support, as well as third-party reimbursement, and that new community mental health centers established under this Act eventually become State-operated or State approved and self-sufficient.

Toward that end, the Committee proposal would require that before any application for a grant for preparation (under section 101), for community mental health center operation (under section 102), for services to priority populations (under section 105), or—beginning in fiscal year 1984—for non-revenue-producing activities (under section 106) may be approved by the Secretary, the application must receive the approval of the State Mental Health Authority. State-operated CMHCs are exempted from this review requirement. To avoid an unnecessary series of health planning reviews under the provisions of Title XV of the Public Health Service Act, the Committee intends that this new State Mental Health Authority approval process occur at the outset of a grant application; if approved by the State mental health authority, the applicant could then proceed to submit its proposals for appropriate Health Systems Agency review.

In return for this delegation of authority, the Systems Act would require that the State develop its statewide services and provide assurances regarding the sufficiency of the non-Federal share of its approved CMHC applicants' revenues. In much the same fashion as the present law, the Systems Act provides that no State or entity within a State may be eligible to receive a grant under this Act unless the State has in effect an adequate State mental health services plan. This plan must be consistent with the relevant provisions of the State health plan, as prepared in accordance with Title XV of the Public Health Service Act. The Systems Act also requires that any application for an operations grant under section 102 of this Act be accompanied by satisfactory assurances from the State mental health authority that the grant applied for and other revenues (including State and local funds and third-party payments) will be sufficient to meet the center's projected costs for the year.

This interposal of a State review is explicitly intended to accomplish the two goals of expansion and coordination of services and long-term CMHC funding that is independent of Federal monies. The Committee intends, therefore, that States use this new authority to approve applications in a considered effort to plan, distribute, and make available as many high quality services to as many people as possible and not in an arbitrary manner or in a manner calculated only to limit expenditures. The Committee further intends that the Secretary consider all proposals on the basis of the quality of the need for services, as well as the likelihood that services will be supported and continued by State and other non-Federal revenues.

In Title II of H.R. 7299, the Committee proposes two other programs to improve the State's provision of mental health services. Authorizations of appropriations are made for programs to aid States in the administration of mental health programs. The collection and use of statistical data, planning and administration, and program evaluation are specifically enumerated as eligible projects although other activities which will improve mental health service provision are also permissible. It is the Committee's intent that these funds be used for new programmatic improvements and not for routine services or the supplantation of other funds.

There are also included in Title II authorizations of appropriations for pilot programs for the State administration of grants under this Act. Section 202 would authorize the Secretary to enter into agreements with State mental health authorities to disburse Federal funds provided under grants under this Act and to review the performance of grantees, as well as to perform other functions under the grant programs. The Committee anticipates that such pilot projects will be instructive in the further development of a more active State role in the provision of mental health services. Finally, the committee intends that there shall be no discrimination on the basis of race, creed, color, or political affiliation with respect to the administration of programs supported by this legislation at the State or local level.

C. PREVENTION

In mental health care delivery as with other types of health care delivery, the Committee is of the opinion that prevention and early intervention techniques are, in theory, the least costly course of action in terms of both actual dollar outlays and less-easily-measured human costs. The Committee has received reports, for example, that mutual support programs for the bereaved or preliminary work with children who are to be hospitalized may avert serious psychological disturbances. The Committee is, however, concerned that the prevention of mental illness is a largely unexplored and undefined activity. In order to promote a better understanding of this field, the Committee's proposal would authorize the Secretary to make grants to public and nonprofit private entities to demonstrate and fully evaluate the potential effectiveness of programs to prevent the onset or worsening of mental illness. It is the Committee's hope that these programs will provide definition and models for use within community mental health centers, as well as a variety of other settings.

D. ASSOCIATE DIRECTOR OF NATIONAL INSTITUTE OF MENTAL HEALTH FOR MINORITY CONCERNS

Title V of H.R. 7299, as reported, deals with the special concerns of minority groups. The Committee intends that, for the purposes of this title, the term "minority" shall also include women. The Committee proposal establishes within the National Institute of Mental Health the position of Associate Director for Minority Concerns. The Secretary, acting through this office, is required: to support programs for mental health service delivery to minority populations; support research on the mental health problems of minority populations; develop a plan to increase the representation of minority populations in mental health research and service delivery; support programs to promote understanding of the needs of minority populations; study the effect of discrimination on institutions and individuals; and support research, demonstration, and training programs aimed at eliminating institutional discrimination. These programs are to be supported by grants to and contracts with public and nonprofit private entities.

During its consideration of this Act, the Committee received much information as to the special and unmet mental health needs of ethnic minorities and women. The Committee is concerned that some existing CMHCs may not be adequately providing the services to these groups that are required under the present Community Mental Health Centers Act and anticipates that the Department of Health and Human Services will review its programs to assure that minorities and women are appropriately served. In adopting this provision, the Committee further intends that the Associate Director for Minority Concerns will also promote services and research projects to meet the special needs of minorities.

E. EXTENSION OF COMMUNITY MENTAL HEALTH CENTERS ACT THROUGH 1981

H.R. 7299 would extend the existing authorizations under the Community Mental Health Centers Act for fiscal year 1981, in the amount of $78 million. This extension is included within the enactment of the Mental Health Systems Act because the Committee believes that any attempt to implement the revised and new authorities before 1981 would be precipitous and would severely disturb ongoing programs. The Committee intends, therefore, that, before fiscal year 1982, the mental health programs authorized under the Centers Act will be continued in an efficient and routine fashion, and that, although some preparation for the initiation of the Systems Act will become necessary, it should be accomplished with as little disruption to existing programs as possible.

In addition, the Committee expects the Department to monitor, on a regular basis, existing CMHC program activities and to enforce the requirements of current law. In response to concerns raised during its oversight hearings, the Committee intends that particular efforts should be undertaken to insure that access to needed mental health services is available to all members of the community.

F. RAPE SERVICES SUPPORT PROGRAM

(1) Background and Need

Congressional initiative specifically targeted to rape treatment and control began with the enactment of the Health Revenue Sharing and Health Services Act of 1975 (Public Law 94–63). That legislation focused on the largely unexplored research problems of rape, the new concepts of special services to rape victims, and the comparatively small numbers of nationwide rape programs. Part D of Title II of the Act established a National Center for the Prevention and Control of Rape within the National Institute of Mental Health. The Center supports research and research demonstration projects related to rape; maintains a clearinghouse to provide information and educational materials on prevention, treatment, and rehabilitation efforts; and develops training materials related to sexual assault. The legislation also authorized the Secretary of HEW to appoint an advisory committee to advise, consult, and make recommendations regarding the Center's activities.

Currently, most rape victim services of accompaniment, counseling, consultation, and public education are performed by local rape crisis centers (RCCs). These centers vary in their funding arrangements, organization, range of services, and delivery mechanisms. Many are run totally by volunteers. Both volunteer efforts and more established centers lack an assured, continual funding source. Many RCCs depend upon contributions or occasional grants and contracts from state, local, and law enforcement sources. It is estimated that approximately 50% of the time of RCC staff is spent trying to locate funding to meet immediate needs. This, in turn, reduces the staff's time to provide victim services. This tenuous financial support situation has resulted in the periodic closure of RCCs. Testimony from witnesses appearing before the Health Subcommittee during the hearing held in June, 1979 expressed concern for the fragile financial position of RCCs.

Rape crisis centers have communicated to Congress the need for legislation supporting direct victim services. The Committee has received reports that if modest Federal support were given to existing RCCs, these Centers would be able to concentrate on finding long-term funding sources to maintain their financial viability.

This would also free the staff from the time-consuming activities of fundraising, thus making it possible for them to devote their time to victim services.

Federal support for RCCs was recommended in the National Rape Prevention and Control Advisory Committee's annual report to the Secretary of HEW (November, 1978). The Advisory Committee also took the position that such funding should go directly to rape crisis centers.

(2) Proposed Legislation

The Committee's bill authorizes the Secretary of HEW to award grants and contracts to public and nonprofit private rape crisis centers (RCCs) to assist in meeting the costs of providing direct services to rape victims. Types of direct services eligible for funding under this section include: accompaniment of the victim to medical, social, and legal services; counseling and referral services to the victim and the

victim's immediate family, basic operating expenses, e.g. telephone hot-lines, office space, and utilities; consultation with allied professionals; and public education materials and programs. (Expenditures for transportation are to be limited to actual costs of victim accompaniment and shall not include purchase of a vehicle.)

The Committee intends for this program to assist existing RCCs to achieve self-sufficiency through the establishment of long-term public and private funding sources. Applicants who are currently providing services are, therefore, to receive first priority in funding. Only entities which provide a specialized rape victim services component in their delivery of services are to be eligible to apply under this section.

The bill provides for the establishment of a grant review panel composed of individuals who have worked or are currently working in the delivery of services to rape victims. The Committee intends that the Secretary, in choosing members of this panel, shall select persons with at least two years of rape service experience. The Committee further intends that the Secretary consult with such persons and with other experts prior to the promulgation of proposed guidelines to be used by the grant review panel in its determination of awards.

The Committee believes that coordination of efforts among Federal programs dealing with the issue of rape is imperative and has, therefore, instructed the Secretary to coordinate these various activities. In addition, the Committee expects the Secretary to place responsibility for this program within a service agency of the Department.

Technical assistance is to be given only to those RCCs which the Secretary determines do not possess the resources or expertise necesary to develop and submit applications. No more than 10 percent may be obligated of the appropriated funds for technical assistance.

The Committee's bill also recognizes and emphasizes the importance of confidentiality for victims and the protection of service providers. Information obtained by the recipient of a grant or contract is to be immune from legal process and may only be admitted as evidence or otherwise used in civil or criminal action or other judicial or administrative proceedings with the consent of the person furnishing the information.

G. PUBLIC HEALTH SERVICE—COMMISSIONED CORPS SPECIAL PAY

Background and Need

The Congress authorized establishment of the Commissioned Corps of the Public Health Service (PHS) in 1889. The objective was to create a mobile, highly qualified, and strongly motivated cadre of medical and scientific personnel to meet the complex health problems facing the nation.

The Commissioned Corps is a flexible personnel system that is modeled along military lines, and its officers have titles and pay grades corresponding to those of the military services. Under the "rank-in-man" concept, the grade and pay are vested in the officer, and are retained upon reassignment. Moreover, each officer, upon appointment, must agree to "serve in any area or position or wherever the exigencies of the Service may require."

In time of war or national emergency, the President may declare that the Public Health Service Commissioned Corps is a branch of the land and naval forces of the United States. In such circumstances, Public Health Service commissioned officers are subject to the same requirements as members of the armed forces, including the Uniform Code of Military Justice. The Public Health Service now provides health professionals to staff the Coast Guard medical activities.

As Federal involvement in health care issues expanded, so did the Commissioned Corps. Congress authorized a reserve component in 1918 and later passed legislation to permit health professionals other than physicians to enter the Commissioned Corps personnel system. There are now eleven categories in the Commissioned Corps—medical, dental, nursing, sanitary engineering, scientist, sanitarian, veterinary medicine, pharmacy, dietitian, therapy, and health services.

Throughout its nearly 100 years of experience, the Commissioned Corps has provided outstanding leadership to the Nation's health efforts. The Corps has played an important role in the control of such diseases as cholera, polio, pellagra, leprosy, diphtheria, tuberculosis, measles, Legionnaries' Disease, and the eradication of smallpox from the world. Today, the Corps continues to be involved in the improvement of health, responding to such problems as Three Mile Island; the growing needs of refugees; spills of toxic substances; and the health care of the poor, migrants, native Americans and those living in remote areas.

At the present time many health agencies rely on PHS physicians:

TABLE I: *Distribution of PHS commissioned corps physicians by agency as of March 1980*

Agency	*Commissioned Corps Physicians*
National Institutes of Health	634
National Health Service Corps	586
PHS Hospitals	566
Indian Health	506
Center for Disease Control	233
Alcohol, Drug Abuse, and Mental Health Administration	96
Assistant Secretary for Health Office	49
Food and Drug Administration	35
Health Care Financing Administration	9
Health Resources Administration	6
Health Services Administration	3
Environmental Protection Agency	3
Total	2,726

Since 1947, the Congress has conscientiously avoided making a distinction between Armed Forces and Public Health Service physicians. The PHS is designed along military lines with military rank and pay for its officers. The pay grades and allowances for Public Health Service commissioned officers are now the same as the pay grades and allowances for officers in the other uniformed services. In addition, Public Health Service commissioned officers have the same retirement benefits, including disability retirement benefits, that pertain to members of the other uniformed services.

The current system of variable Incentive Pay was created in 1974 and was intended to be a temporary 2-year measure, pending the development of a much needed comprehensive and equitable system of physician pay for the uniformed services.

In April of this year, the Chairman and the Ranking Minority Members of the Committee and its Subcommittee on Health and the Environment wrote to the Chairman of the Committee on Armed Services urging comparability for Public Health Service officers in any special pay legislation subsequently reported from the Committee on Armed Services. That letter noted that:

> The recent action of the President in vetoing H.R. 5235, the Uniformed Services Health Professionals Special Pay Act of 1980, is deeply disturbing. Particularly distressing is his assertion that inclusion of the Commissioned Corps of the Public Health Service in this legislation is unnecessary.
>
> The Commissioned Corps of the Public Health Service faces the same dilemma as that faced by the Armed Services in recruiting and retaining physicians. Shortages approximating 15 percent occur today, and greater shortages are predicted for the future unless the provisions which your committee so wisely provided in H.R. 5235 are enacted.

The Chairman of the Committee on Armed Services responded on April 17, 1980, that:

> Following extended formal and informal communication with the Executive Branch, the Military Compensation Subcommittee reported a bill to the full committee that provided for a restructuring of the special pay for physicians of the Army, Navy and Air Force identical to the provisions of H.R. 5235....
>
> On April 1, 1980, the full committee agreed to report H.R. 6982 as reported from the subcommittee.

The mandated levels of remuneration have, however, remained fixed at 1974 levels. Variable Incentive Pay has been extended by voice vote of the Congress annually since 1976, while a more comprehensive proposal was in preparation.

H.R. 5235, the "Uniformed Services Health Professionals Special Pay Act of 1980", was thus developed by the Committee on Armed Services as specific legislation to replace the Variable Incentive Pay provisions that are due to expire on September 30, 1980. The bill was not an expansion of the Armed Forces Physicians Pay Act, but rather a long overdue product of Congress and a move toward the development of a comprehensive pay act for all of the Uniformed Services, designed to correct many longstanding physician pay problems.

On March 11, 1980, the President vetoed H.R. 5235. Among the reasons given for the veto was an objection to the inclusion of special pay for Public Health Service physicians on an equal basis with military physicians.

(*2*) *Proposed Legislation*

At this time, the provisions of the Committee proposal relating to special pay for PHS physicians are necessary if comparability between PHS and other uniformed services is to be maintained. Such comparability is desirable because any major policy distinction that divorces the PHS Commissioned Corps from its stature as an equal member of the Uniformed Services, would relegate the PHS Commissioned Corps to a non-competitive, second-class status. Under the

legislation reported from the Committee on Armed Services, there would be a significant difference in special pay between PHS physicians and physicians in the Armed Services.

The increase proposed by the Committee on Armed Services averages less than $3,000 per physician. As noted previously, the special pay has not increased since 1974. Even with the increased special pay a young, board-certified specialist physician would earn only $38,000 a year. This $38,000 compares with an average income of more than $55,000 for private physicians in the first five years of practice.

At the present time, there are shortages of 15 percent in PHS physician positions. Great increases in these shortages are projected if comparability is not maintained. Such increased shortages would severely affect the various health agencies which currently rely heavily on PHS physicians, the Public Health Service hospitals, the Indian Health Service, the Center for Disease Control, and the National Institutes of Health. The Committee believes, in fact, that if the Committee proposal is not adopted the resulting pay differentials, not only between the private sector and the PHS but also between the Armed Services and the PHS, could result in the eventual demise of the Public Health Service Commissioned Corps.

The Committee believes that the professionals of the Commissioned Corps of the Public Health Service are a vital part of the nation's health effort. The continued availability of such professionals in critical to operation of such programs as the Public Health hospitals, the Indian Health Service, the Center for Disease Control, and the National Institutes of Health. The Committee proposal thus provides that the special pay provided to physicians and dentists in the Public Health Service shall be the same as that provided, now and hereafter, to such professionals in the Armed Forces under Chapter 5 of Title 37. The Committee emphasizes that under its proposal any increase in special pay for Armed Forces professionals in future years would also be provided to PHS professionals. In this manner, the Committee intends to ensure both current and future comparability of pay between PHS and Armed Forces health professionals.

Program Oversight

The Committee's principal oversight activities with respect to the provisions of this bill were conducted by the Subcommittee on Health and the Environment in an oversight hearing on the Community Mental Health Centers Program on February 5, 1980; in a hearing on community support programs for the mentally ill on October 11, 1979; and in connection with its legislative hearings on the proposals contained in this bill which were conducted on June 14, 25, and 26, 1979. The proposals contained in this bill are designed to respond to the Subcommittee's findings. The Committee has not received reports from its own Subcommittee on Oversight and Investigations or the Committee on Government Operations.

Inflation Impact Statement

The Committee knows of no inflationary effect of this legislation and expects rather that the provision of mental health care for the potentially chronically mentally ill will accomplish significant over-

all savings in direct outlays and national resources. The high cost of inpatient institutional care has been documented by many reports and much information supplied to the Committee. By coordinating and expanding the availability of less expensive and less restrictive alternatives to such programs, the Committee anticipates that public and private monies will be more efficiently used.

Agency Reports

Agency reports were requested on H.R. 4156, a similar predecessor bill to H.R. 7299, on June 14, 1979, from the Office of Management and Budget; the Department of Health, Education, and Welfare; and the Department of Labor. The following responses were received by the Committee:

Executive Office of the President,
Office of Management and Budget,
Washington, D.C., July 16, 1979.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your request of June 6, 1979 for the views of this Office on H.R. 4156, a bill "To improve the provision of mental health services and otherwise promote mental health throughout the United States; and for other purposes."

H.R. 4156 is identical to draft legislation submitted by the Secretary of Health, Education, and Welfare on May 15, 1979. The bill is based on the recommendations of the President's Commission on Mental Health and provides a flexible approach by which States and communities can plan and implement programs that meet the mental health needs of their citizens, with emphasis on high risk and underserved groups.

We concur with the views expressed by the Secretary of Health, Education, and Welfare in his transmittal letter. Accordingly, we recommend that the Committee give favorable consideration to the bill. Enactment of H.R. 4156 would be in accord with the program of the President.

Sincerely,

Naomi R. Sweeney,
Acting Assistant Director for Legislative Reference.

Department of Health, Education, and Welfare,
June 29, 1979.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your request for a report on H.R. 4156, a bill "To improve the provision of mental health services and otherwise promote mental health throughout the United States; and for other purposes".

H.R. 4156 is the Administration's mental health proposal, transmitted as a draft bill to the Speaker of the House on May 15 of this year. A copy of our transmittal letter is enclosed.

We urge that the Committee give H.R. 4156 its prompt and favorable consideration.

The Office of Management and Budget advises that enactment of H.R. 4156 would be in accord with the program of the President.

Sincerely,

HALE CHAMPION,
Acting Secretary.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
May 15, 1979.

Hon. THOMAS P. O'NEILL,
Speaker of the House of Representives,
Washington, D.C.

DEAR MR. SPEAKER: Enclosed for consideration by the Congress is a draft bill entitled "The Mental Health Systems Act"; a detailed summary of the bill is also enclosed.

The report by the President's Commission on Mental Health has pointed to the great progress we have made in reaching and treating the mentally ill and in returning people to their families and communities through successful community-based mental health programs. However, this report also pointed to the serious need for more programs to help chronically mentally ill adults and children to live outside of institutions and for better targeting of community-based services on inadequately served populations, such as the aged, the poor, racial and ethnic minorities, children and youth, and residents of rural areas. The report also recommended that greater flexibility be provided in funding mental health services to meet community needs than is permitted under the existing Community Mental Health Centers Act; that steps be taken to ensure more effective mental health manpower distribution; and that programs to emphasize prevention and early detection of mental disorders be established.

The proposed Mental Health Systems Act stems from the recommendations of the President's Commission. It provides a flexible approach by which States and communities can plan, develop, and implement programs that systematically and comprehensively meet the mental health needs of their citizens, with emphasis on high risk and underserved groups.

Under the enclosed draft bill, States will, as a condition of participating in its benefits, have to develop mental health plans that assess mental health service and manpower needs, particularly for high risk, underserved, or inadequately served population groups. These plans will also have to show how the rights of the mentally disabled will be protected and must, in addition, provide for protecting the interests of employees of institutions whose interests are adversely affected by a required emphasis on community-based care instead of institutional care.

Title I of the bill would authorize performance-based project grants to be used by the States to support State and local level planning for, and development of, a system of mental health and support services (such as other health, housing, transportation, and social services) for chronically mentally ill adults and children who need both types of services to help them live in noninstitutional settings; for State and local coordination of these services; for improving at both levels the availability of and competency of personnel providing these services; and for providing retraining and job placement help to former institutional employees adversely affected by the emphasis on noninstitutional care for the chronically mentally ill. We would use this authority primarily to accomplish the goals, established by the President's Commission on Mental Health, of assisting the chronically mentally ill through phasing down large State mental hospitals, upgrading the quality of services in remaining institutions, and providing quality aftercare services and appropriate alternatives to institutionalization. Under title II of the bill project grants would be available to the States to promote the development of prevention services through planning, information, training, and demonstration programs. We would use this authority primarily for demonstration programs. It would complement Federal programs, under existing legislation, of research and training aimed at preventing mental illness. Title III of the draft bill recognizes and builds upon the role of the States have played in the financing and administration of mental health services. It would authorize project grants to the States to help them improve their data analysis, planning, performance standard setting and enforcement, and monitoring and evaluation capacity in the mental health area.

The community mental health services title of the draft bill (title IV) would provide continuity with the earlier national goal of access to the comprehensive mental health services under the existing Community Mental Health Centers Act while providing more flexibility in funding than has been available in the past. A variety of new grant authorizations in this title will allow community agencies to implement effective mental health programs that are sensitive to their own as well as to Federal and State priorities. Special linkage grants will encourage coordination and integration of mental health services provided in mental health or primary care settings. Finally, funding for community mental health centers under the existing grant programs could be continued for the length of time provided under current law.

A special manpower provision amends Section 303 of the Public Health Service Act to improve the distribution of mental health personnel by requiring those receiving training assistance under that section of the Act to work in unserved or underserved areas.

This bill repersents an important initiative that will advance the progress we have made in improving the mental health of our citizens. We urge the Congress to give it prompt and favorable consideration.

We are advised by the Office of Management and Budget that enactment of the draft bill would be in accord with the program of the President.

Sincerely,

JOSEPH A. CALIFANO, JR.,
Secretary.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

A cost estimate was requested on H.R. 7299 when it was ordered reported from the Committee on Interstate and Foreign Commerce, and the Congressional Budget Office has provided the following information:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., May 15, 1980.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 7299, the Mental Health Systems Act.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

ALICE M. RIVLIN,
Director.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 7299.
2. Bill title: Mental Heath Systems Act.
3. Bill status: As ordered reported by the House Committee on Interstate and Foreign Commerce on May 13, 1980.
4. Bill purpose: Principally, the bill would extend for fiscal year 1981 the authorizations for certain programs under the Community Mental Health Centers (CMHC) Act; authorize revised mental health services programs for fiscal years 1982, 1983 and 1984; asd authorize for fiscal years 1981 through 1984 a new program of services for victims of rape. In addition, the bill would require: (1) that recipients of clinical traineeships under Sec. 303 of the Public Health Service (PHS) Act either provide specified service in return or repay three times the amount of the traineeship plus maximum allowable interest; and (2) that commissioned medical and dental officers in the PHS Corp be paid special pay at the same rate and under the same conditions as such officers in the armed services.
5. Cost estimate:

[By fiscal years, in millions of dollars]

	1981	1982	1983	1984	1985
AUTHORIZATION LEVELS					
CMHC Act:					
Planning (202)(d)	1.0				
Initial operations (203)(d)(1)	37.0				
Consultation and education (204)(c)	15.0				
Financial distress (213)	15.0				
Rape prevention and control (231)(d)	4.0				
Mental Health Systems Act:					
Preparation (101)(d)		1.0	1.0	1.0	
Initial operations (102)(d)(1)		24.0	27.0	30.0	
Chronically mentally ill (103)(d)		32.6	38.0	43.0	
Severely disturbed children (104)(d)		7.0	8.0	9.0	
Priority populations (105)(d)		16.0	18.0	20.0	
Nonrevenue producing activities (106)(d)		35.0	40.0	45.0	
Ambulatory centers (107)(c)		15.0	17.5	20.0	
Administrative improvements (201)(b)		3.0	4.0	5.0	
Pilot projects (202)(b)		3.0	4.0	5.0	
Demonstration projects (301)(c)		6.0	8.0	10.0	
Services for rape victims (601)(d)(1)	6.0	9.0	12.0	12.0	
Total authorization levels	78.0	151.6	177.5	200.0	
ESTIMATED OUTLAYS					
CMHC Act:					
Planning (202)(d)	.25	.65	.10		
Initial operations (203)(d)(1)	9.25	24.05	3.70		
Consultation and education (204)(c)	3.75	9.75	1.50		
Financial distress (213)	3.75	9.75	1.50		
Rape prevention and control (231)(d)	1.00	2.60	.40		
Mental Health Systems Act:					
Preparation (101)(d)		.25	.90	1.00	0.75
Initial operations (102)(d)(1)		6.00	22.35	27.45	22.20
Chronically mentally ill (103)(d)		8.15	30.69	38.71	31.75
Severely disturbed children (104)(d)		1.75	6.55	8.15	6.65
Priority populations (105)(d)		4.00	14.90	18.30	14.80
Nonrevenue producing activities (106)(d)		8.75	32.75	40.75	33.25
Ambulatory centers (107)(c)		3.75	14.13	17.88	14.75
Administrative improvements (201)(b)		.75	2.95	4.15	3.65
Pilot projects (202)(b)		.75	2.95	4.15	3.65
Demonstration projects (301)(c)		1.50	5.90	8.30	7.30
Services for rape victims (601)(d)(1)	1.50	6.15	9.45	11.70	9.00
Total estimated outlays	19.5	88.6	150.72	180.54	147.75

The costs of this bill fall within budget function 550.

6. Basis for estimate: Authorized amounts are assumed to be appropriated in full at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of appropriate recent program data.

CBO expects that Sec. 801 of this bill, which would mandate specified service in return for mental health traineeships, would have no significant impact on outlays. The requirement of triple repayment in lieu of compulsory service is so severe that CBO assumes that almost all recipients of traineeships would serve as required.

Because, under current law, commissioned PHS physicians and dentists receive special pay in the same amounts and under the same conditions as such personnel in the armed forces, the provision of this bill requiring such equal treatment would have no cost.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Malcolm J. Curtis.

10. Estimate approved by:

C. G. Nuckols
(For James L. Baum, Assistant
Director for Budget Analysis).

SECTION-BY-SECTION ANALYSIS

Sec. 1. Short Title and Table of Contents.

Section 1 provides the Act's short title, "Mental Health Systems Act."

A Table of Contents for this Act follows section 1.

TITLE I—COMMUNITY MENTAL HEALTH SERVICES

Preparation Grants

Sec. 101 authorizes the Secretary to make grants to those public or nonprofit private entities recommended by the State Mental Health Authority to prepare for providing mental health services within a mental health service area. Such grants may be made for projects to assess needs for mental health services, to design programs to meet these assessed needs, to obtain financial and professional assistance and support for such programs and to encourage community involvement in them. The grant may not exceed $75,000 and no mental health service area may receive more than one. Any service area which has previously received a grant under section 202 of the Community Mental Health Centers Act (Planning Grants) is precluded from receiving a grant under this section. Authorizations of appropriations for such grants are provided in the amount of $1 million for each of fiscal years 1982, 1983, and 1984.

Grants for Community Mental Health Centers

Sec. 102 authorizes the Secretary to make grants to public and nonprofit private community mental health centers (CMHCs) to assist in meeting their costs of operation. Eligibility for such grants is limited to CMHCs that are State-operated or have been approved by the State Mental Health Authority; applications must be accompanied by assurances from the State Mental Health Authority and satisfactory to the Secretary that the grant and all other funds the CMHC may reasonably be expected to receive will be sufficient to meet the costs of operation for the year in which the grant is to be made. Eligibility for such grants is limited to the first eight years of the CMHC's operation. The amount of a grant is to be the lesser of (a) the amount equal to the amount by which a CMHC's costs of operation exceed its other revenues, or (b) a percentage (which is prescribed for each grant year) of the CMHC's costs of operation. Authorizations of appropriations are provided for initial operations of CMHCs of $24 million in fiscal year 1982; $27 million in fiscal year 1983; and $30 million in fiscal year 1984. For fiscal year 1982 and each of the next nine fiscal years, there are also authorized such sums as may be necessary for continuation grants under this section.

Grants for Services for the Chronically Mentally Ill

Sec. 103 authorizes the Secretary to make grants to State mental health authorities, CMHCs, and other public and nonprofit private entities for services to assist the chronically mentally ill. Such services include case management; assistance in gaining access to medical, dental, mental health, and rehabilitation services; assistance in gaining access to employment and housing; and other support services.

In the award of such grants, the Secretary is to give special consideration to projects which supplement existing community services.

The Secretary shall give priority first to approved applications of State mental health authorities, second to those of CMHCs, and finally to those of other public and private nonprofit entities in areas where CMHCs do not exist. In areas where CMHCs do exist, only the CMHC and the State Mental Health Authority are eligible to apply.

The section authorizes for this purpose $32.6 million for fiscal year 1982; $38 million for fiscal year 1983; and $43 million for fiscal year 1984.

Grants for Services for Severely Mentally Disturbed Children and Adolescents

Sec. 104 authorizes the Secretary to make grants to State Mental Health Authorities, CMHCs, and other public and nonprofit private entities for mental health services and other support services for lies. In making such grants, the Secretary shall give priority first to approved applications of State Mental Health Authorities, second severely mentally disturbed children and adolescents and their famito those of CMHCs, and finally to those of other public and private nonprofit entities in areas in which CMHCs do not exist. In areas where CMHCs do exist, only the CMHC and the State Mental Health Authority are eligible to apply.

For these purposes, the section authorizes $7 million in fiscal year 1982; $8 million in fiscal year 1983; and $9 million in fiscal year 1984.

Grants for Mental Health Services for Priority Populations

Sec. 105 authorizes the Secretary to make grants to State-run or State-recommended public or private nonprofit entities for projects which are designed to provide mental health services to those identifiable population groups within a mental health service area which have been determined to be unserved or underserved by mental health programs; such determination is to be made under a health systems plan or a State plan under section 1513 (Functions of Health Systems Agencies) or 1524 (Statewide Health Coordinating Council) of the Public Health Service Act.

Eligibility is limited to projects which make outpatient mental health services and two of six other specified services available to all residents of a mental health service area not served by a CMHC. An applicant must also present a satisfactory plan for the provision of all six of the described services by the end of its third year of funding; during the fourth and fifth years of funding under this section, a grantee must provide all six of the described services. No more than two such grants may be made in any single mental health service area during the same fiscal year. No entity may receive more than five such grants for service for the same group and no mental health service area may receive more than ten such grants.

The amount of each grant shall be determined by the Secretary. The fourth and fifth such grants, however, may not exceed 60 percent and 30 percent, respectively, of the project's costs. Authorizations of appropriations for such grants are provided in the amount of $16 million for fiscal year 1982; $18 million for fiscal year 1983; and $20 million for fiscal year 1984.

Grants for Non-Revenue-Producing Activities

Sec. 106 authorizes the Secretary to make grants to CMHCs to assist in meeting the costs of consultation and education services, followup services, and program administration. Eligibility is limited to those

CMHCs which have exhausted their eligibility for operations grants and which continue to provide at least the six services required for initial operations support for a CMHC. Beginning in fiscal year 1984, eligibility is further limited to State-run or State-recommended CMHCs.

No CMHC may receive more than five such grants. The amount of each grant shall be determined by the Secretary, but may not exceed $1.00 per capita for the population of the mental health service area. Authorizations of appropriations for such grants are provided in the amount of $35 million for fiscal year 1982; $40 million for fiscal year 1983; and $45 million for fiscal year 1984.

Grants for mental health services in ambulatory health care centers

Sec. 107 authorizes the Secretary to make grants to assist ambulatory health care centers to participate in the provision of mental health services to their patients. Eligible applicants are (1) public or nonprofit private entities which provide at least emergency and outpatient mental health services and consultation and education services, and (2) public or nonprofit private ambulatory health care centers. Each application must include an affiliation agreement between a provider of ambulatory health care services and a mental health care provider. Authorizations of appropriations for such grants are provided in the amount of $15 million for fiscal year 1982; $17.5 million for fiscal year 1983; and $20 million for fiscal year 1984.

Grants for members of Indian tribes or organizations

Sec. 108 authorizes the Indian Health Service, upon request of any Indian tribe or urban Indian organization, to apply to the Secretary for any grant under this title. Such grants shall be made on the same terms as apply to non-Federal entities, although, in accord with other provisions of this Act, the Secretary may fund up to 100 percent of the costs of the projects to be supported by such grants. Such grants may be made even though the project to be funded serves residents of two or more mental health service areas of a State.

Grants for innovative projects

Sec. 109 authorizes the Secretary to make grants to public and nonprofit private entities for (1) projects for the training and retraining of employees adversely affected by changes in mental health service delivery systems and for assistance in securing employment, (2) projects for the innovative use of personnel in the management and delivery of mental health services, and (3) other significant innovative mental health projects. For such purposes, the Secretary may obligate up to 5 percent of the funds appropriated under Title I of this Act in any fiscal year. Of the funds so obligated, no less than 50 percent shall be used for training and employment projects.

TITLE II—STATE PROGRAM

Grants to improve the administration of State mental health programs

Sec. 201 authorizes the Secretary to make grants to State mental health authorities for projects for data collection and analysis, improvements in planning and administration, improvements in program evaluation, or any other activities to improve mental health pro-

grams in the State. Authorizations of appropriations for such grants are made in the amount of $3 million for fiscal year 1982; $4 million for fiscal year 1983; and $5 million for fiscal year 1984.

Pilot Projects for State Administration of Grants

Sec. 202 authorizes the Secretary to enter into agreements with State mental health authorities under which the authorities will disburse Federal funds under this Act, review performance of programs funded under this Act, and perform such other functions as the Secretary and the State mental health authority agree upon. The Secretary is further authorized to make grants to State mental health authorities to meet their costs in carrying out such agreements. Authorizations of appropriations for such grants are made in the amount of $3 million in fiscal year 1982; $4 million in fiscal year 1983; and $5 million in fiscal years 1984.

TITLE III—PREVENTION

Demonstration Projects

Sec. 301 authorizes the Secretary to make grants to public and nonprofit private entities to demonstrate and evaluate the effectiveness of intervention techniques and mental health promotion activities in the prevention of mental illness. Authorizations of appropriations for such grants are made in the amount of $6 million in fiscal year 1982; $8 million in fiscal year 1983; and $10 million in fiscal year 1984.

TITLE VI—GENERAL PROVISIONS

Part A—State Plans

State mental health services plans.—Sec. 401 provides that in order for the State Mental Health Authority or any entity in a State to be eligible to receive a grant under this Act, the State must have in effect a State mental health services plan which is consistent with the State health plan prepared under section 1524 (Statewide Health Coordinating Council) of the Public Health Service Act and which has been approved by the Secretary as meeting the requirements of this Act.

If, after notice and opportunity for a hearing to the State agency, the Secretary determines that the plan no longer meets these requirements or that there is a failure to comply with these requirements, the Secretary is empowered to discontinue grants to the State Mental Health Authority and to any other entity in the State receiving funds under this Act.

Contents of plans.—Sec. 402 prescribes the contents of a State mental health services plan. In its administrative part, such plan must include provision for: (1) a single State agency to administer the plan, (2) an advisory council to consult with this agency, (3) the making of reports and keeping of records, (4) statistics collection, (5) periodic review and modification of the plan, and (6) personnel standards.

In its services part, such plan must (1) identify the State's mental health services areas; (2) identify the needs, and the adequacy of resources to meet such needs; (3) describe the proposed allocation of resources; (4) describe proposals to coordinate State and local services; (5) describe the legal rights of mentally ill persons; and (6) provide for emphasis of outpatient mental health services, including protections for employees adversely affected by such programs.

Part B—Applications and Related Provisions

Applications.—Sec. 403 prescribes the content of an application for a grant under this Act. Such application must include, among other items: (1) a budget; (2) a statement of purpose; (3) in the case of a project funded under Title I under which health services are to be provided, assurances satisfactory to the Secretary that the applicant has prepared a schedule of fees and discounts and has made every reasonable effort to secure payment and reimbursement for services; (4) assurances that the applicant has established a requirement that the mental health care of every patient must be under the supervision of a member of the professional staff and that a staff member must be available to furnish emergency mental health care; (5) satisfactory assurances that the applicant has a system to assure that an employee of the applicant who reports the applicant's failure to comply with applicable State law or Federal law or regulation will not be discharged or discriminated against on account of such report; (6) satisfactory assurances that each facility to be used in the provision of health or support services to be supported by the grant applied for meets the requirements of applicable fire and safety codes imposed by State law; (7) satisfactory assurances that funds under this Act will not supplant non-Federal monies; and (8) satisfactory assurances that the project is consistent with the State mental health services plan.

Technical assistance.—Sec. 404 authorizes the Secretary to obligate up to 2 percent of the total amount appropriated under titles I and II for any fiscal year for technical assistance to any State mental health authority or other entity which is or has been a recipient of a grant under this Act to aid in mental health services program development and administration.

Part C—Grant Limits

Limits on grants.—Sec. 406 provides that no mental health services area may receive more than a total of ten grants under:

(1) Section 220 of the Community Mental Health Centers Act (as in effect before the date of the enactment of the Community Mental Health Centers Amendments of 1975);

(2) Section 203 of the Community Mental Health Centers Act (Grants for Initial Operations);

(3) Section 102 of this Act (Grants for Community Mental Health Centers); and

(4) Section 105 of this Act (Grants for Mental Health Services for Priority Populations).

Part D—Performance

Performance standards.—Sec. 407 provides that the Secretary shall prescribe standard measures of performance to test the quality and extent of performance by grantees usder this Act and the extent to which such performance has helped achieve national and other objectives for which grants were made. In determining whether or not to approve an application for a grant under this Act, the Secretary is also to consider the performance by the applicant under any prior grant under this Act as measured by the standards prescribed under this section.

Evaluation and monitoring.—Sec. 408 provides that, with the approval of the Secretary, any recipient of a grant under this Act may

use a portion of that grant for the evaluation of the project or activity involved and of the recipient's program of which the project or activity is a part. The section also authorizes the Secretary to obligate not more than 1 percent of the total amount appropriated under this Act for any fiscal year to monitor activities of grantees under this Act. Such monitoring may be done directly or through contracts with State mental health authorities.

Part E—Definitions

Definition of community mental health center.—Sec. 409(a) defines a community mental health center as a legal entity through which mental health services are provided principally to individuals residing in a mental health service area, and—within the limits of its capacity—to any individual residing or employed within such area, regardless of ability to pay, health conditions, or any other factor.

Sec. 409(b)(1)(A) provides that beginning on the date the community mental health center is established for purposes of this Act, the services provided through the center shall include: (1) inpatient services; (2) emergency services; (3) outpatient services; (4) assistance to courts and other public agencies in screening residents for referral to State mental health facilities and provision, where appropriate, of treatment of such persons through the center as an alternative to inpatient treatment; (5) follow-up care for residents who have been discharged from inpatient mental health treatment; (6) consultation and education services; and (7) the provision of six other prescribed services, as described in section 409(b)(1)(B), or a plan approved by the Secretary under which the center will, during the three-year period beginning on its date of establishment, assume in increments the provision of those six additional services and will, upon the expiration of such three-year period, provide all six of those services.

Sec. 409(b)(1)(B) provides that after the expiration of such three-year period, a community mental health center shall provide the following services in addition to the six basic services required for initial operations:

(1) day care and other partial hospitalization services;

(2) a comprehensive program of specialized services for the mental health of children;

(3) a comprehensive program of specialized services for the mental health of the elderly;

(4) a program of transitional half-way house services for mentally ill residents of the mental health service area who have been discharged from inpatient treatment or would, without such a program, require inpatient treatment;

(5) a program for prevention and treatment of alcoholism and alcohol abuse (unless the Secretary determines that the need for this program is not present or is being met within the mental health service area); and

(6) a program for the prevention and treatment of drug addiction and abuse (unless the Secretary determines that the need for this program is not present or is being met within the mental health service area).

Sec. 409(b)(2) requires that services provided through a community mental health center be coordinated with those of other health

and social service agencies (including State mental health facilities) in or serving the same area. The center's services are to be provided at the center or satellite centers and through its staff or through arrangements with health professionals and others in the mental health service area. Inpatient services, emergency services, and transitional half-way house services may, however, be provided by arrangements with health professionals and others outside the mental health service area but serving that area.

Sec. 409(b)(3) provides that, consistent with State law, medical services provided by a center to individual patients are to be under the direction and supervision of a physician. Whenever possible, the physician providing such direction and supervision shall be a psychiatrist.

Sec. 409(c)(1) specifies that the governing board of a community mental health center shall be composed, when practicable, of representative individuals who reside within the center's mental health services area. The board shall meet at least monthly and shall establish the center's general policies, approve its budgets and appoint its director. No more than one-half of the members of this board may be providers of health care.

Sec. 409(c)(2) provides that, if a community mental health center is operated by a governmental agency or a hospital, it may appoint an advisory committee in lieu of meeting the requirements of section 409(c)(1). This committee is to be made up of representative residents of the center's mental health service area and no more than one-half of its members may be providers of health care.

Sec. 409(d) requires that each community mental health center have a quality assurance program, an adequate medical records system, a professional advisory board, and an administrative unit responsible for the provision of the consultation and education services. The Secretary may waive the last of these requirements at any center if he determines the requirement to be unwarranted.

Other definitions.—Sec. 410(1) specifies that the term "Secretary" means the Secretary of Health and Human Services.

Sec. 410(2) provides that the term "ambulatory health care center" may include a hospital outpatient facility, a community health center, a migrant health center, a clinic of the Indian Health Service, a skilled nursing home, an intermediate care facility, and other specified outpatient health care facilities.

Sec. 410(3) specifies that the term "State Mental Health Authority" means the agency of a State responsible for its mental health programs.

Sec. 410(4) requires that each State be covered by one or more mental health service areas, that such areas (except to the extent permitted by the Secretary) be the same as or contained within a health service area established under Title XV of the Public Health Service Act (National Health Planning and Development), and, to the extent practicable, that such areas have boundaries conforming to those of one or more school districts or other subdivisions in the State.

Part F—Miscellaneous

Indirect provision of services.—Sec. 411 provides that, except as specified in section 409(b)(2), any entity which is responsible for the

provision of a mental health service for purposes of a grant under this Act may provide the service directly at its primary or satellite facilities or through arrangements with other entities or health professionals in or serving the same mental health service area.

Cooperative agreements.—Sec. 412 authorizes the Secretary to provide funds under this Act under cooperative agreements as well as grants.

Contract authority.—Sec. 413 provides that the authority of the Secretary to enter into contracts under this Act shall be effective for any fiscal year only to the extent or in such amounts as provided in advance by appropriation Acts.

TITLE V—MINORITY CONCERNS

Associate Director of National Institute of Mental Health

Sec. 501 establishes within the National Institute of Mental Health the position of Associate Director for Minority Concerns. The Secretary, acting through this office, is required: to support programs for mental health service delivery to minority populations; support research on the mental health problems of minority populations; develop a plan to increase the representation of minority populations in mental health research and service delivery; support programs to promote understanding of the needs of minority populations; study the effect of discrimination on institutions and individuals; and support research, demonstration, and training programs aimed at eliminating institutional discrimination. These programs are to be supported by grants to and contracts with public and nonprofit private entities.

TITLE VI—RAPE SERVICES SUPPORT PROGRAM

Grants for services for rape victims

Sec. 601 authorizes the Secretary to make grants to and enter into contracts with public and nonprofit private entities to assist in meeting the costs of (1) providing counseling and follow-up counseling for rape victims and their immediate families; (2) providing assistance in securing mental health, social, medical, and legal services for rape victims; and (3) projects to develop and implement methods of preventing rape and aiding rape victims. The amount of such grant or contract shall be determined by the Secretary but may not exceed 90 percent of the project's cost. A grant review panel is established to advise the Secretary on approval of applications.

The Secretary is required to coordinate the activities conducted under this section with other similar Federal programs. The Secretary is authorized to obligate no more than 10 percent of the funds appropriated for this section for technical assistance in the development of applications.

The section forbids diclosure of information obtained by the recipient of a grant or contract unless the disclosure is to carry out a purpose for which the information was obtained.

Authorizations of appropriations for grants under this section are made in the amounts of $6 million in fiscal year 1981; $9 million in fical year 1982; $12 million in fiscal year 1983; and $12 million in fiscal year 1984.

TITLE VII—EXTENSION OF COMMUNITY MENTAL HEALTH CENTERS ACT

One-year extension of Community Mental Health Centers Act

SEC. 701 extends programs of the existing Community Mental Health Centers Act for one year. Eligibility for financial distress grants under section 211 of that Act is increased from five years to six years.

Authorizations of appropriations for grants under this section are made for fiscal 1981 in the following amounts: $1 million for grants for planning; $37 million for grants for initial operations; $15 million for grants for consultation and education; $15 million for financial distress grants; and $4 million for rape prevention and control.

TITLE VIII—MISCELLANEOUS

Obligated service for mental health traineeships

SEC. 801 amends section 303 of the Public Health Service Act (relating to Mental Health) by adding the requirement that, after the enactment of this Act, any individual who receives a clinical traineeship under that section for training in the specified mental health specialties shall be obligated to serve in a State mental institution, a health manpower shortage area, or in other areas designated by the Secretary. Service shall be at the rate of one year for each year of the traineeship and shall commence at the end of the traineeship. Any individual who fails to perform this required service shall be obligated to repay three times the cost of the traineeship plus maximum legal interest.

Conforming amendments

Sec. 802(a) amends section 507 of the Public Health Service Act (relating to Grants to Federal Institutions) to allow Federal Institutions to receive grants under this Act at up to 100 percent of their costs.

Sec. 802(b) amends section 513 of the Public Health Service Act (relating to Evaluation of Programs) to allow the Secretary to obligate up to 1 percent of the appropriations under this Act for program evaluation.

Sec. 802(c) amends sections 1513 (relating to the Functions of Health Systems Agencies) and 1524 (relating to the Statewide Health Coordinating Council) to require that the health planning agencies review and approve proposed grants under this Act.

Special pay for Public Health Service physicians and dentists

Sec. 803 amends section 208 of the Public Health Service Act (relating to Pay and Allowances) to require that commissioned medical and dental officers of the Public Health Service Corps be paid special pay at the same rate as similar officers in the Armed Forces.

Mental health personnel

Sec. 804 amends section 303 of the Public Health Service Act (relating to Mental Health) to add a declaration of shortages in the fields of psychiatry and other mental health care specialties.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is closed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman) :

COMMUNITY MENTAL HEALTH CENTERS ACT

* * * * * * *

GRANTS FOR PLANNING COMMUNITY MENTAL HEALTH CENTER PROGRAMS

SEC. 202. (a) * * *

* * * * * * *

(d) There are authorized to be appropriated for payments under grants under subsection (a) $3,750,000 for the fiscal year 1976, $3,750,000 for the fiscal year ending September 30, 1977, $1,930,000 for the fiscal year ending on September 30, 1978, $1,500,000 for the fiscal year ending September 30, 1979, and $1,000,000 [for the fiscal year ending September 30, 1980] *each for the fiscal year ending September 30, 1980, and the next fiscal year.*

GRANTS FOR INITIAL OPERATION

SEC. 203. * * *

* * * * * * *

(d)[(1)] There are authorized to be appropriated for payments under initial grants under subsection (a) $50,000,000 for fiscal year 1976, $55,000,000 for the fiscal year ending September 30, 1977, $38,890,000 for the fiscal yearending September 30, 1978, $34,500,000 for the fiscal year ending September 30, 1979, [and] $35,000,000 for the fiscal year ending September 30, 1980, *and $37,000,000 for the fiscal year ending September 30, 1981.*

*[(2) For fiscal year 1980, and for each of the succeeding seven fiscal years, there are authorized to be appropriated such sums as may be necessary to make payments under continuation grants under subsection (a) to community mental health centers and other entities which first received an initial grant under this section for fiscal year 1976, or the next four fiscal years and which are eligible for a grant under this section in a fiscal year for which sums are authorized to be appropriated under this paragraph.]

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*Effective October 1, 1981.

GRANTS FOR CONSULTATION AND EDUCATION SERVICES

SEC. 204. * * *

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(c) There are authorized to be appropriated for payments under grants under this section $10,000,000 for fiscal year 1976, $15,000,000 for the fiscal year ending September 30, 1977, $15,000,000 for the fiscal year ending September 30, 1978, $20,000,000 for the fiscal year ending September 30, 1979, [and] $3,000,000 for the fiscal year ending September 30, 1980, *and $15,000,000 for the fiscal year ending September 30, 1981.*

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GRANT REQUIREMENTS

SEC. 212. (a) * * *

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(c) Each grant under this section to a grantee shall be made for the projected costs of operation (except the costs of providing the consultation and education services described in section 201(b)(1)(D)) of such grantee for the one-year period beginning on the first day of the first month in which such grant is made. No community mental health center may receive more than [five] *six* grants under section 211.

* * * * * * *

AUTHORIZATION OF APPROPRIATIONS

SEC. 213. There are authorized to be appropriated $15,000,000 for fiscal year 1976, $15,000,000 for the fiscal year ending September 30, 1977, $13,500,000 for the fiscal year ending September 30, 1978, [and] $25,000,000 for the fiscal year ending September 30, 1979, *and $15,000,000 for the fiscal year ending September 30, 1981*, for payments under grants under section 211.

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PART D—RAPE PREVENTION AND CONTROL

RAPE PREVENTION AND CONTROL

SEC. 231. (a) * * *

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(d) For the purpose of carrying out subsection (b), there are authorized to be appropriated $7,000,000 for fiscal year 1976, $10,000,000

for the fiscal year ending September 30, 1977, $7,880,000 for the fiscal year ending September 30, 1978, $8,000,000 for the fiscal year ending September 30, 1979, [and] $9,000,000 for the fiscal year ending September 30, 1980, *and $4,000,000 for the fiscal year ending September 30, 1981.*

PUBLIC HEALTH SERVICE ACT

* * * * * * *

PAY AND ALLOWANCES

SEC. 208. (a) (*1*) Commissioned officers of the Regular and Reserve Corps shall be entitled to receive such pay and allowances as are now or may hereafter be authorized by law.

(*2*) *Commissioned medical and dental officers in the Regular and Reserve Corps shall while on active duty be paid special pay in the same amounts as, and under the same terms and conditions which apply to, the special pay now or hereafter paid to commissioned medical and dental officers of the Armed Forces under chapter 5 of title 37, United States Code.*

* * * * * * *

MENTAL HEALTH

SEC. 303. (a) * * *

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(*d*) (*1*) *Any individual who has received a clinical traineeship, in psychology, psychiatry, nursing, or social work, under subsection (a) (1) that was not of a limited duration or experimental nature (as determined by the Secretary) is obligated to serve, in service determined by the Secretary to be appropriate in the light of the individual's training and experience, at the rate of one year for each year (or academic year, whichever the Secretary determines to be appropriate) of the traineeship.*

(*2*) *The service required under paragraph (1) shall be performed—*

(*A*) *for a State mental institution providing inpatient care or any entity receiving a grant under the Mental Health Systems Act,*

(*B*) *in a health manpower shortage area (as determined under subpart II of part D of this title), or*

(*C*) *in any other area or for any other entity designated by the Secretary,*

and shall begin within such period after the termination of the traineeship as the Secretary may determine. In developing criteria for determining for which institutions or entities or in which areas, referred to in the preceding sentence, individuals must perform service under paragraph (1), the Secretary shall give preference to institutions, entities, or areas which in his judgment have the greatest need for personnel to perform that service. The Secretary may permit service for or in other institutions, entities, or areas if the Secretary determines that the request for such service is supported by good cause.

(*3*) *Any individual who fails to perform the service required under this subsection within the period prescribed by the Secretary is obli-*

gated to repay to the United States an amount equal to three times the cost of the traineeship (including stipends and allowances) plus interest at the maximum legal rate at the time of payment of the traineeship, multiplied, in any case in which the service so required has been performed in part, by the percentage of the length of the service so required to be performed which has not been performed.

(4)(A) In the case of any individual any part of whose obligation to perform service under this subsection exists at the same time as any part of his obligation to perform service under section 752 or 753 (because of receipt of a scholarship under subpart IV of part C of title VII) or his obligation to perform service under section 472 (because of receipt of a National Research Service Award), or both, the same service may not be used to any extent to meet more than one of those obligations.

(B) In any case to which subparagraph (A) is applicable and in which one of the obligations is to perform service under section 752 or 753, the obligation to perform service under that section must be met (by performance of the required service or payment of damages) before the obligation to perform service under this subsection or under section 472.

(C) In any case to which subparagraph (A) is appliable, if any part of the obligation to perform service under section 472 exists at the same time as any part of the obligation to perform service under this subsection, the manner and time of meeting each obligation shall be prescribed by the Secretary.

(e) Because of the rising demands for mental health services and the wide disparity in the distribution of psychiatrists, clinical psychologists, social workers, and psychiatric nurses, there is a shortage in the medical specialty of psychiatry and there are also shortages among the other health personnel who provide mental health services.

* * * * * * *

GRANTS TO FEDERAL INSTITUTIONS

SEC. 507. Appropriations to the Public Health Service available under this Act for research, training, or demonstration project grants or for agents to expand existing treatment and research programs and facilities for alcoholism, narcotic addiction, drug abuse, and drug dependence, and appropriations available under the Community Mental Health Centers Act for construction and staffing of community mental health centers and alcoholism and narcotic addiction, drug abuse, and drug dependence facilities, *and appropriations under the Mental Health Systems Act*, shall also be available, on the same terms and conditions as apply to non-Federal institutions, for grants for the same purpose to Federal institutions, except that grants to such Federal institutions may be funded at 100 per centum of the costs.

* * * * * * *

EVALUATION OF PROGRAMS

SEC. 513. Such portion as the Secretary may determine, but not more than 1 per centum, of any appropriation for grants, contracts, or other payments under any provision of this Act, the Mental Retardation Facilities Construction Act, the Community Mental Health Cen-

ters Act, *the Mental Health Systems Act*, the Act of August 15, 1954 (Public Law 568, Eighty-third Congress),[1] or the Act of August 16, 1957 (Public Law 85–151),[1] for any fiscal year beginning after June 30, 1970, shall be available for evaluation (directly, or by grants or contracts) of any program authorized by this Act or any such other Acts, and, in the case of allotments from any such appropriation, the amount available for allotment shall be reduced accordingly.

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FUNCTIONS OF HEALTH SYSTEMS AGENCIES

SEC. 1513. (a) * * *

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(e)(1)(A) Except as provided in subparagraph (B), each health systems agency shall review and approve or disapprove each proposed use within its health service area of Federal funds—

(i) appropriated under this Act, the Community Mental Health Centers Act, *the Mental Health Systems Act*, sections 409 and 410 of the Drug Abuse Office and Treatment Act of 1972, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 for grants, contracts, loans, or loan guarantees for the development, expansion, or support of health resources by any entity other than the government of a State unless such resources are solely within the health service area of such agency; or

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STATEWIDE HEALTH COORDINATING COUNCIL

SEC. 1524. (a) * * *

* * * * * * *

(c) * * *

(6) Review annually and recommend approval or disapproval of (A) any State plan and any application (and any revision of a State plan or application) submitted to the Secretary as a condition to the receipt of any funds under allotments made to States under this Act, the Community Mental Health Centers Act, *the Mental Health Systems Act*, section 409 of the Drug Abuse Office and Treatment Act of 1972, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, and (B) any application (and any revision of an application) submitted to the Secretary by a State for a grant or contract under any provision of law referred to in clause (A) for projects in more than one health service area of the State. Notwithstanding any other provision of this Act or any other Act referred to in the preceding sentence, the Secretary shall allow a SHCC sixty days to make the review required by such sentence. If a SHCC recommends disapproval of such a plan or application, the Secretary, after making a finding that such plan or application is not in conformity with the State health plan, may not make Federal funds available under such State plan or application. If the Secretary makes such a finding, he shall notify the Governor of his fiinding and the reasons therefor and advise him that he has thirty days in which to submit a revised State plan or applica-

tion that conforms with the State health plan. If after reviewing a recommendation of a SHCC to disapprove such State plan or application, the Secretary decides to make such funds available, the decision by the Secretary to make such funds available shall be submitted to the SHCC and shall contain a detailed statement of the reasons for the decision.

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DISSENTING VIEWS ON H.R. 7299—MENTAL HEALTH SYSTEMS ACT OF 1980

Many millions of dollars have been spent over the years to build staff and operate Community Mental Health Centers. The large bulk of those millions has come from the federal government. As with so many programs which extend back in time—in this case to 1963—the original concept was to offer formula grants to the states to induce them to replace the traditional inadequate institutions with smaller, community-based facilities. It was the theory that diagnosis and treatment of mental disorders and, particularly, incipient mental disorders could be more effectively treated in the more familiar surroundings of the "home town." There was nothing wrong with this theory, and where states created the required mental health plan and established a series of community centers, the results ranged from satisfactory to spectacular. Had the program stopped there, it would have been one of the more inspired efforts in federal legislation.

One who has followed federal grant programs in any detail could already guess what came next. The states immediately came back to Congress with the plaintive plea that although the bricks and mortar were most welcome, they (the states and communities) did not have the wherewithal to hire the necessary professional staffs. So a new kind of grant was invented to support initial staffing. This support was to continue for four years on a descending scale and then phase out. Need we say what happened? This assistance was eventually extended for as much as eight years and expanded to include other than professional staffs. Support of continuing operations has been running over $200 million a year and will continue to do so for some years. This money is nowhere reflected in the legislation, but it will nonetheless be expended in addition to any sums set forth in this bill.

Aside from the staffing support, the programs being now carried on under the Community Mental Health Centers Act received appropriations in fiscal year 1980 totaling $65.473 million. The bill proposes $78 million for these activities in fiscal year 1981. Beginning in fiscal year 1982, however, new programs are added which approximately double the fiscal year 1981 proposed authorization. The need today is to balance the budget—not to double our spending. These additional activities do little, if anything, to enhance the quality and effectiveness of mental health care.

In fact, beyond failing to enhance mental health care, the bill can, and undoubtedly will, fragment and frustrate such efforts. New authorities overlap and outright duplicate some existing authorities. By creating new categories of need, the bill undermines the basic purpose of the overall program to achieve comprehensive, community-based mental health services.

In addition to the past programs, and the new ones aimed at diagnosis and treatment of mental health ailments, this bill would start the

federal government upon an entirely new tack with projects to prevent mental illness. The possible ramifications of such efforts can be frightening from both a philosophical and a fiscal point of view. The $2.287 billion already spent will appear like the proverbial drop in the bucket. It might occur to many that the very best thing the federal government can do to help prevent mental illness in the population is to strive to keep a very low profile.

Present programs seem to be working reasonably well. Whether the taxpayers should be asked to maintain without diminution those programs under present circumstances is certainly open to question. To ask them to double the outlays in this one area at this time is unconscionable. A simple renewal of authorization at existing levels is the most that can be justified.

Samuel L. Devine.
James M. Collins.
Gary A. Lee.
Tom Corcoran.
William E. Dannemeyer.
Dave Stockman.

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